§ 58-67-5. Definitions.

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Enrollee" means an individual who is covered by an HMO.

(c) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

(d) "Health care plan" means any arrangement whereby any person undertakes on a prepaid basis to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services on a prepaid basis through insurance or otherwise.

(e) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(f) "Health maintenance organization" or "HMO" means any person who undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles. For the purposes of 11 U.S.C. § 109(b) (2) and (d), an HMO is a domestic insurance company.

(g) "Person" includes associations, trusts, or corporations, but does not include professional associations, or individuals.

(h) "Provider" means any physician, hospital, or other person that is licensed or otherwise authorized in this State to furnish health care services.

(i) "Net worth" means the excess of total assets over the total liabilities and may include borrowed funds that are repayable only from the net earned income of the health maintenance organization and repayable only with the advance permission of the Commissioner. For the purposes of this subsection, "assets" means (i) tangible assets and (ii) other investments permitted under G.S. 58-67-60.

(j) "Working capital" means the excess of current assets over current liabilities; provided that the only borrowed funds that may be included in working capital must be those borrowed funds that are repayable only from net earned income and must be repayable only with the advance permission of the Commissioner.

(k) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the HMO; or in the case of an individual contract, the person in whose name the contract is issued.

(l) "Participating provider" means a provider who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, directly or indirectly, from the HMO, other than copayment or deductible.

(m) "Insolvent" or "insolvency" means that the HMO has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(n) "Carrier" means an HMO, an insurer, a nonprofit hospital or medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

(o) "Discontinuance" means the termination of the contract between the group contract holder and an HMO due to the insolvency of the HMO and does not mean the termination of any agreement between any individual enrollee and the HMO.

(p) "Uncovered expenditures" means the amounts owed or paid to any provider who provides health care services to an enrollee and where such amount owed or paid is (i) not made pursuant to a written contract that contains the "hold harmless" provisions defined in G.S.

58-67-115; or (ii) not guaranteed or insured by a guaranteeing organization or insurer under the terms of a written guarantee or insurance policy that has been determined to be acceptable to the Commissioner. "Uncovered expenditures" includes amounts owed or paid to providers directly from the HMO as well as payments made by a medical group, independent practice association, or any other similar organization to reimburse providers for services rendered to an enrollee. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1987, c. 631, s. 1; 1989, c. 776, ss. 2, 3, 15; 1991, c. 195, s. 4; c. 720, s. 40; 2001-417, s. 13; 2003-212, s. 19.)